Concentra

Discovery
Support Services

Record Certification

Discovery Support Services, LLC Use Only

The undersigned certifies that he/she is a representative of Discovery Support Services, LLC and that they made true reproductions of the applicable original records concerning Cisco Charles Hicks (Patient) which were kept in the offices of Concentra (Provider) during the period of 2006 - 2009, whose original items, documents, and/or records are provided to Discovery Support Services, LLC by the custodian of records for the aforementioned Healthcare Provider.

12/17/10
Date

Signature

Document Number 03.14.02

PLAINTIFF'S EXHIBIT
Trial 15

MEDTOX LABORATORIES INC.
402 WEST COUNTY ROAD D
ST. PAUL, MN 55112
651-636-7466

Jennifer A. Collins, Ph.D.
Dr Mark Catlin, M.D.
Karla Walker, Pharm.D.

COMPUTER-GENERATED FACSIMILE LABORATORY REPORT

ICSAS
ATTN: DR FRANCES ANEROUSIS
ANDERSON-KELLY ASSOCIATES INC
500 INTERNATIONAL DR, STE 205
MOUNT OLIVE, NJ 07828

PATIENT NAME: HICKS,CIRO
Social Security: [redacted]

PATIENT I.D. NO.: M1840111
AGE:
SEX: M
SPECIMEN: F1151916
DOB:

REDLICH,ADAM/

DATE COLLECTED: 06/19/2008
TIME COLLECTED: 14:30
DATE RECEIVED: 06/20/2008
DATE REPORTED: 06/24/2008 6:07AM

TEST(S) REQUESTED	RESULTS		UNITS	THERAPEUTIC RANGE
CBC WITH PLATELET AND DIFFERENTIAL				
WHITE BLOOD CELL COUNT	10.75		thou/mm3	3.90-11.40
RED BLOOD CELL COUNT	4.82		mil/mm3	4.10-5.80
HEMOGLOBIN	15.7		g/dl	13.5-17.5
HEMATOCRIT	47.0		%	38.0-50.0
MCV	97.6	(H)	fl	80.0-97.0
MCH	32.5		pg	27.0-34.0
MCHC	33.4		%	31.0-35.0
RDW	13.6		%	11.0-15.5
PLATELET COUNT	334		thou/mm3	140-400
MPV	8.7		fl	7.5-11.5
NEUT (PERCENT)	44.2		%	40.0-80.0
LYMPH (PERCENT)	50.8	(H)	%	15.0-50.0
MONO (PERCENT)	2.8		%	0.0-10.0
EOS (PERCENT)	1.7		%	0.0-6.0
BASO (PERCENT)	0.6		%	0.0-2.0
ABS NEUT COUNT	4750		cells/mm3	1800-8000
ABS LYMPH COUNT	5460	(H)	cells/mm3	1000-4000
ABS MONO COUNT	300		cells/mm3	40-950
ABS EOS COUNT	180		cells/mm3	30-600
ABS BASO COUNT	60		cells/mm3	0-125
COMMENT	SEE TEXT	(*)		

PATHOLOGY REVIEW: MILD LYMPHOCYTOSIS REVIEW HISTORY AND PHYSICAL FINDINGS.
REVIEWED BY DR. MARK CATLIN 6/23/2008

*** FINAL REPORT ***

Department of Homeland Security
U.S. Coast Guard
CG-719K (Rev 03/04)

Merchant Mariner Physical Examination Report

OMB (1625-0040)
Expires 07/31/2009

Section I -- Applicant Information

Name (Last, First, Middle) of Applicant: Hicks, Clyde, C

Date of Birth (Month, Day, Year): [redacted]

Social Security Number: [redacted]

Section II - Physical Information

Eye Color	Hair Color	Weight	Distinguishing Marks
Blue.	Blond	216 lbs	

Height	Blood Pressure	Pulse Rating
ft 69 in	Systolic 118 / Diastolic 70	62 ☑ Regular ☐ Irregular

Section III - Vision (if you have corrected vision, BOTH uncorrected & corrected MUST be shown)

UNCORRECTED	CORRECTABLE TO	FIELD OF VISION
Right 20 / 50	Right 20 /	☑ Normal ☐ Abnormal
Left 20 / 25	Left 20 /	The applicant must have 100 degrees horizontal field of vision

Section IV - Color Vision

☑ PASS ☐ FAIL

Deck Officers/Ratings (masters, mates, pilots, operators, able-seaman) must be tested using one of the following tests. For all other licenses/ratings, see page 1, note 3.

Pseudoisochromatic Plates
- ☐ Dvorine - 2nd Edition
- ☐ AOC
- ☐ AOC Revised Edition
- ☐ AOC - HRR
- ☐ Ishihara 16, 24, 36 Plate Edition

- ☐ Eldridge - Green Perception Lantern
- ☐ Farnsworth Lantern (FALANT)
- ☐ Keystone Orthoscope
- ☐ Keystone Telebinocular
- ☐ SAMCTT - School of Aviation Medicine
- ☑ Titmus Optical Vision Test
- ☐ Williams Lantern

Section V - Hearing

☑ NORMAL ☐ IMPAIRED (If impaired, complete Audiometer and Functional Speech Discrimination Test)

Audiometer (Threshold Value)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right Ear (Unaided)	15	10	15	40
Left Ear (Unaided)	10	15	10	25
Right Ear (Aided)				
Left Ear (Aided)				

Functional Speech Discrimination Test at 55 dB

Right Ear (Unaided) _____ % Left Ear (Unaided) _____ %

Right Ear (Aided) _____ % Left Ear (Aided) _____ %

Section VI - Medications

List all current medications, including dosage and possible side effects. State the condition(s) for which the medication(s) are taken.

☐ NO PRESCRIPTION MEDICATIONS

LOTREL

Spirometry Report
Puritan-Bennett Renaissance II
S/N: G-20021270573
Version: 1.1.11

CONCENTRA EDISON

BEST FVC/FVL REPORT

Session Date: 12AUG2008
Session Time: 12:07PM
Last Cal Check: 12AUG2008

ID: 050422129
Name: HICKS,CIRO
Gender: MALE
Medication:
Dosage:

Height: 69" Physician:
Age: 57YRS Technician:
Weight: 216LBS
Smoker: 40YRS, 80 Pack Yrs
Ethnicity/Correction: CAUCASIAN 100.0%

Sensor Code: 546778
Temperature: 70f
Barometric Press: /60mmHg
BTPS Correction: 1.110
Normals: KNUDSON 83

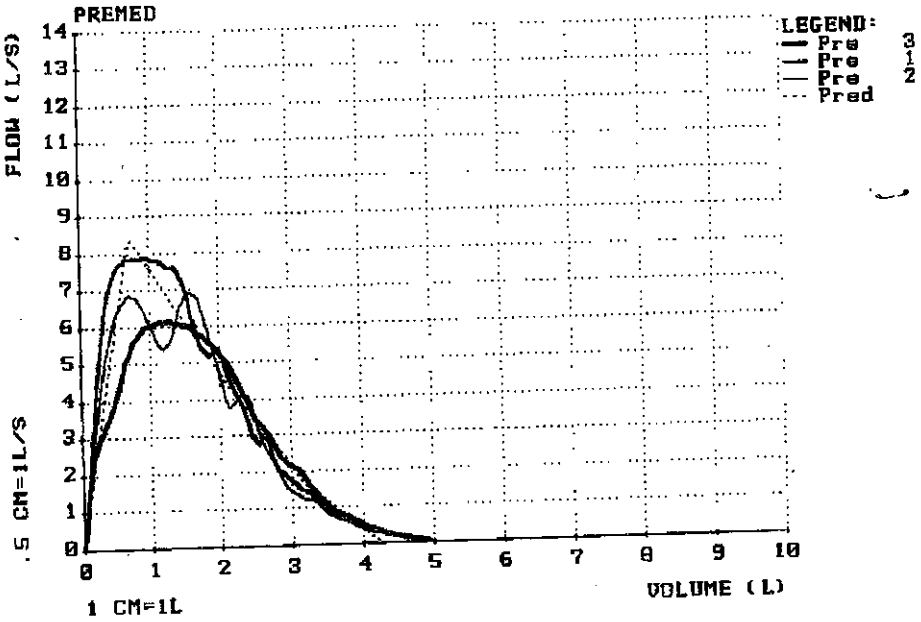
< Indicates Below LLN

User Format: PREMED - 12:08PM
Best Criteria: VAL

MEASUREMENT	QC	BEST	Trial	%Pred	Pred	LLN
FVC (L)	F	4.96	3	115	4.29	3.15
FEV1 (L)	F	3.53	3	102	3.46	2.67
FEV1%		71		88	81	70
FEF25-75 (L/S)		2.43	3	68	3.56	
PEF (L/S)		6.20	3	73	8.46	
FET (S)		7.71	3			

Report Summary:
Pre Med: Tests 3 Acceptable 0 Reproducible 2 FVC VAR: 158ML FEV1 VAR: 55ML PEF VAR: 1722ML/S

AIS Interpretation: PREMED - Normal Spirometry
Lung Age: 57 YRS
Comment:



Concentra™ physical therapy

Vane Brothers Post-Offer Test

Client Name: [illegible]

SSN: [redacted]

Date of Test: 8/6/08

Baseline Heart Rate:	66/MIN
Age Predicted Maximum 220-Age:	153
85% of Age Predicted Maximum 220- Age x .85:	130

Testing will be stopped for any component, if the candidate's heart rate level reaches 85% of their Age Predicted Maximum. Testing may resume when the candidate's heart rate returns to their baseline heart rate level.

Material Handling Activities

	Weight	Activities		Repetitions	Score	HR
Lift	40	Floor to Waist		2	Pass / Fail	90
Lift	40	Waist to Shoulder		2	Pass / Fail	78
Lift	40	Waist to Overhead		2	Pass / Fail	78
Carry	40	Distance: feet	20 feet	2	Pass / Fail	84
Push-Pull	40 lbs of force	Distance: feet	20 feet	10	Pass / Fail	120
UE Push-Pull	27 lbs of force	Distance:	UE only	2	Pass / Fail	72
Simulated Rope Toss		20 lbs on cable column		3 on each side	Pass / Fail	72
Grip Strength	40 lbs of force	Average of 4 trials:	120 lbs		Pass / Fail	72
Pinch Strength	15 lbs of force	Average of 4 trials	22 lbs		Pass / Fail	72
Hand Dominance:		(R) HAND				

Health Questionnaire
Questions Related to the Strength and Step Tests

Please circle the appropriate answer:

1. Are you presently restricted from lifting or pulling by any physician?	YES (NO)
2. Have you recently had any surgery which should limit your lifting or pulling?	YES (NO)
3. Are you presently placed on medical limitations by your employer or doctor?	YES (NO)
4. Has your doctor ever said you have heart trouble?	YES (NO)
5. Are you having back pain?	YES (NO)
6. Do you have high blood pressure(greater than140/90)?	YES (NO)
7. Have you recently experienced chest discomfort with exertion or shortness of breath for no apparent reason?	YES (NO)
8. Do you often feel faint or have spells of severe dizziness?	YES (NO)
9. Have you ever had a blood clot? If YES, where?_____; when?_____	YES (NO)
10. Do you often feel faint or have spells of severe dizziness?	YES (NO)
11. Do you currently have an uncontrolled metabolic disease (diabetes, thyrotoxosis, gout, myxedema, etc.) or serious disorder (mononucleosis, hepatitis, etc.)?	YES (NO)
12. Has your doctor ever told you that you have a bone, joint or musculoskeletal problem, such as arthritis or sciatica, that has been made worse by exercise or are you currently under medical care for any bone, joint or musculoskeletal problem?	YES (NO)
13. Are you currently taking any prescription or non-prescription medications? If YES, what and when last taken?_____	YES (NO)
14. Do you have asthma? If YES, are you on daily medications and if so, what and when last taken? _____	YES (NO)
15. Are you pregnant?	YES (NO)
16. Is there a good physical reason not mentioned here why you should not perform these tests even if you wanted to?	YES (NO)

I understand the above questions and have answered them truthfully to the best of my knowledge.
I feel physically able to perform the strength and step test.

Employee Signature | Nico Charles Hicks (Name (Please Print)) | 8-12-08 (Date)

Injury/Private Account History

Pittsburgh CBO
Data Current as of 7:53 AM 12/22/2010

Account: 480943360
Patient: Hicks, Ciro Charles,
DOI: 08/12/2008
Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748

SSN: [redacted]
DOB: [redacted]
Agency:

Employer: Vane Brothers
Address: 2100 Frankfurst Ave
Baltimore, MD 212261026

Phone: (410) 631-5096

Payor:
Address:

Phone: ( ) -

Report Criteria
DOS Range: 01/22/2000 - 12/22/2010
Account #: 480943360
Include/Exclude Notes: N

Account Summary By DOS

	DOS	Check	Chg Total	Pmt Amt	Adj Amt
Audiogram	08/12/2008		39.50	0.00	0.00
Employer - Payment		0000067532	0.00	(39.50)	0.00
Breath Alcohol Test PrePlacement	08/12/2008		34.50	0.00	0.00
Employer - Payment		0000067532	0.00	(34.50)	0.00
HPE ADApt-Level 4	08/12/2008		115.50	0.00	0.00
Employer - Payment		0000067532	0.00	(115.50)	0.00
Physical PrePlacement	08/12/2008		60.00	0.00	0.00
Employer - Payment		0000067532	0.00	(60.00)	0.00
Pulmonary Function Test	08/12/2008		46.50	0.00	0.00
Employer - Payment		0000067532	0.00	(46.50)	0.00
Regulated UDS PrePlacement	08/12/2008		55.50	0.00	0.00
Employer - Payment		0000067532	0.00	(55.50)	0.00
Vision Ishihara/Color	08/12/2008		11.00	0.00	0.00
Employer - Payment		0000067532	0.00	(11.00)	0.00
X-Ray Chest-1 View	08/12/2008		89.50	0.00	0.00
Employer - Payment		0000067532	0.00	(89.50)	0.00
			$452.00	($452.00)	$0.00

Department of Homeland Security
U.S. Coast Guard
CG-719K (Rev 03/04)

Merchant Mariner Physical Examination Report

OMB [illegible]
Expires 07/31/2009
Page 3

Section I – Applicant Information

Name (Last, First, Middle) of Applicant: Hicks, Cinq. C

Date of Birth (Month, Day, Year): [redacted]

Social Security Number: [redacted]

Section II - Physical Information

Eye Color	Hair Color	Weight	Distinguishing Marks
Blue	Blond	216 lbs	

Height	Blood Pressure	Pulse Resting
ft 69 in	Systolic 118 / Diastolic 70	62 ☑ Regular ☐ Irregular

Section III - Vision (if you have corrected vision, BOTH uncorrected & corrected MUST be shown)

UNCORRECTED	CORRECTABLE TO	FIELD OF VISION
Right 20 / 50	Right 20 /	☑ Normal
Left 20 / 25	Left 20 /	☐ Abnormal

The applicant must have 100 degrees horizontal field of vision

Section IV – Color Vision

☐ PASS ☐ FAIL

Deck Officers/Ratings (masters, mates, pilots, operators, able-seaman) must be tested using one of the following tests. For all other licenses/ratings, see page 1, note 3.

Pseudoisochromatic Plates
- ☐ Divorine - 2nd Edition
- ☐ AOC
- ☐ AOC Revised Edition
- ☐ AOC - HRR
- ☐ Ishihara 16, 24, 38 Plate Edition

- ☐ Eldridge - Green Perception Lantern
- ☐ Farnsworth Lantern (FALANT)
- ☐ Keystone Orthoscope
- ☐ Keystone Telebinocular
- ☐ SAMCTT - School of Aviation Medicine
- ☐ Titmus Optical Vision Test
- ☐ Williams Lantern

Section V - Hearing

☐ NORMAL ☐ IMPAIRED (If impaired, complete Audiometer and Functional Speech Discrimination Test)

Audiometer (Threshold Value)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right Ear (Unaided)				
Left Ear (Unaided)				
Right Ear (Aided)				
Left Ear (Aided)				

Functional Speech Discrimination Test at 55 dB

Right Ear (Unaided) _____ % Left Ear (Unaided) _____ %

Right Ear (Aided) _____ % Left Ear (Aided) _____ %

Section VI - Medications

List all current medications, including dosage and possible side effects.
State the condition(s) for which the medication(s) are taken.

☐ NO PRESCRIPTION MEDICATIONS

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Merchant Mariner Physical Examination Report

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Section VII – Certification of Physical Impairment or Medical Conditions

Does the applicant have or ever suffered from any of the following?
IF YES, PROVIDE TEST RESULTS, AS INDICATED.

If YES: • Identify the condition • Any limitations • Is condition controlled • Date of diagnosis • Prognosis

Remarks (Please Print)

Yes	No	
	✓	1. Circulatory System
	✓	a. Heart disease (Stress Test within the past year)
	✓	b. Hypertension (Recent BP reading)
	✓	c. Chronic renal failure
	✓	d. Cardiac surgery (Stress Test within the past year)
	✓	e. Blood disorder/vascular disease
	✓	2. Digestive System
	✓	a. Severe digestive disorder
	✓	3. Endocrine System
	✓	a. Thyroid dysfunction (TSH level within the past year)
	✓	b. Diabetes (State effects on vision & HgbAlc w/in 30 days)
	✓	4. Infectious
	✓	a. Communicable disease
	✓	b. Hepatitis A, B or C
	✓	c. HIV
	✓	d. Tuberculosis
		5. Mental System
		a. Psychiatric disorder
		b. Depression
		c. Attempted suicide
		d. Alcohol abuse
		e. Drug abuse
		f. Loss of memory
		6. Musculoskeletal System
		a. Amputations
		b. Impaired range of motion
		c. Impaired balance/coordination
		7. Nervous System
		a. Epilepsy/seizure
		b. Dizziness/unconsciousness
		c. Paralysis
		8. Respiratory System
		a. Asthma (PFT results within the past year)
		b. Lung disease (PFT results within the past year)
		9. Other
		a. Debilitating allergies
		b. Other eye disease (Corrected/Uncorrected Visual acuity)
		c. Glaucoma (Pressure test results within the past year)
		d. Recent or repetitive surgery
		e. Sleepwalking
		f. Severe speech impediment
		g. Other illness or disability not listed

MVP - on lotrel
mitral valve prolapse
hematuria - had w/u
done - no abnormalities
found
(R) total knee - replacement
tonsillectomy
appendectomy
Astigmatism (R) eye

Considering the findings in this examination, and noting the physical demands that may be placed upon the applicant, I consider the applicant (please check one)

☑ Competent ☐ Not competent ☐ Needing further review

Name of Physician/Physician Assistant/Nurse Practitioner	License Number	Telephone Number	Office Address, City, State, Zip
Shoemberg APR	25MP0009630		

Shoemberg APR
Signature of Physician/Physician Assistant/Nurse Practitioner

8/12/08
Date

I certify that all information provided by me is complete and true to the best of my knowledge

X Signature of Applicant

Date 8-12-08

Department of Homeland Security
U.S. Coast Guard
CG-719K (Rev 03/04)

Merchant Mariner Physical Examination Report

OMB 1625-0040
Expires 07/31/2009
Page 2

Privacy Act Statement

As required by Title 5 United States Code (U.S.C.) 552a(e)(3), the following information is provided when supplying personal information to the U. S. Coast Guard.

1. Authority for solicitation of the information: 46 U.S.C. 2104(a), 7101(c)-(e), 7306(a)(4), 7313(c)(3), 7317(a), 8703(b), 9102(a)(5).

2. Principal purposes for which information is used:
   a. To determine if an applicant is physically capable of performing shipboard duties.
   b. To ensure that a duly licensed Physician/Physician Assistant/Nurse Practitioner conducts the applicant's physical examination/certification and to verify the information as needed.

3. The routine uses which may be made of this information:
   a. This form becomes a part of the applicant's file as documentary evidence that regulatory physical requirements have been satisfied and the applicant is physically competent to hold a merchant mariner license or document.
   b. The information becomes part of the total license or document file and is subject to review by federal agency casualty investigators.
   c. This information may be used by the U. S. Coast Guard and an Administrative Law Judge in determining causation of marine casualties and appropriate suspension and revocation action.

4. Disclosure of this information is voluntary, but failure to provide this information will result in non-issuance of a license and/or merchant mariner's document.

"An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number". The Coast Guard estimates that the average burden for completing this form is 10 minutes. You may submit any comments concerning the accuracy of this burden estimate or any suggestion for reducing the burden to the; Commanding Officer, U.S. Coast Guard National Maritime Center, 4200 Wilson Boulevard, Suite 630, Arlington, VA 22203-1804 or Office of Management & Budget, Paperwork Reduction Project (1625-0040), Washington, DC 20503.

Human Performance Evaluation Consent Form

I understand that I am going to be subjected to a series of tests called "Human Performance Evaluation" hereinafter referred to as "HPE". This HPE will test my capability to perform job-related tasks. I understand that this evaluation is voluntary on my part and that I may refuse to perform any test if I feel incapable of performing for any reason. I may also request the test to stop at any time and/or notify the Tester of any discomfort that I may be experiencing.

As with any testing method of this nature, there are certain inherent risks involved with performance of this evaluation. There is the rare possibility that I might experience some musculoskeletal injury but, because I will be controlling the efforts, this risk remains minimal. I will never be forced to perform any test that I do not want to perform.

By signing this I acknowledge I do not currently have any physical or medical conditions that would limit or restrict my participation in strenuous physical activity or heavy lifting. I have read and fully understand the above description concerning HPE and I agree to participate in this evaluation.

Client Signature

8-12-08
Date

Witness Signature

8/12/08
Date

Marybeth Ripley
08/06/2008 03:26 PM

To: Noami Patino/NorthNewJersey-MedCtr/HS/Concentra@Concentra

cc:

Subject: Vane Brothers

Hi Noami:

Vane Brothers would like to send an employee in for a Merchant Marine Physical. I have attached a copy of the authorization form. I will send you another e-mail with the protocol info. Mr. Hicks would like to come in on 8/11, 8/12 or 8/13. Could you please e-mail me a date/time that is convenient for you?

Is NDI the MRO that you use?

Thanks

Mary Beth Ripley
Account Manager
Maryland
Concentra Medical Centers
Cell Phone: 410-218-2679
Fax: 410-975-4577
marybeth_ripley@concentra.com

- pFax_06Aug2008_11-01-43.tif

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

ATN

SPECIMEN ID NO. 10993[illegible]3

ADVANCED TOXICOLOGY NETWORK
3560 Air Center Cove, Memphis, TN 38118 (888)222-4894

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone and Fax No.

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☒ Pre-employment ☐ Random: ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Drug Tests to be Performed: ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

F. Collection Site Address:

Collector Phone No. _____

Collector Fax No _____

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature, within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

Time of Collection ☐ AM ☐ PM

(PRINT) Collector's Name (First, MI, Last)

Date (Mo, Day, Yr.)

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB:

X _____ Signature of Accessioner

PRINT: Accessioner's Name (First, MI, Last)

Date (Mo, Day, Yr.)

Primary Specimen Bottle Seal Intact

☐ Yes

☐ No, Enter Remark Below

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor

(PRINT) Donor's Name (First, MI, Last)

Date (Mo, Day, Yr.)

Daytime Phone No. _____ Evening Phone No. _____ Date of Birth _____ (Mo, Day, Yr.)

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ REFUSAL TO TEST BECAUSE:
☐ DILUTE ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS _____

X _____ Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my determination/verification for the split specimen (if tested) is:

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON _____

X _____ Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

COPY 4 - EMPLOYER COPY

FEDL ... DRUG TESTING CUSTODY AND CONTROL ...RM

ATN

SPECIMEN ID NO. 1099999C63

ADVANCED TOXICOLOGY NETWORK
3560 Air Center Cove, Memphis, TN 38118 (888)222-4894

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone and Fax No.

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

E. Drug Tests to be Performed: ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify)

F. Collection Site Address:

Collector Phone No.

Collector Fax No.

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark)

☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

11:30 AM PM Time of Collection

JOSEPH _____ (PRINT) Collector's Name (First, M.I., Last)

08/20/08 Date (Mo./Day/Yr.)

SPECIMEN BOTTLE(S) RELEASED TO:

_____ Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB:

X _____ Signature of Accessioner

_____ (PRINT) Accessioner's Name (First, M.I., Last)

Date (Mo./Day/Yr.)

Primary Specimen Bottle Seal Intact

☐ Yes

☐ No, Enter Remark Below

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor

_____ (PRINT) Donor's Name (First, M.I., Last)

8/12/08 Date (Mo./Day/Yr.)

Daytime Phone No. 732 [illegible] Evening Phone No. 732-[illegible]-9605 Date of Birth 7/16/51 Mo. Day Yr.

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5).–DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ REFUSAL TO TEST BECAUSE: ☐ ADULTERATED ☐ SUBSTITUTED ☐ DILUTE

REMARKS

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, M.I., Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my determination/verification for the split specimen (if tested) is:

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, M.I., Last)

Date (Mo./Day/Yr.)

COPY 3 - COLLECTOR COPY

AUG-26-08 03:50PM FROM-CONCENTRA 4106339604 T-263 P.001/003 F-888

Concentra™
treated right

Improving America's health, one patient at a time.

1833 Portal Street
Baltimore, Maryland 21224
Phone 410-633-3600
Fax 410-633-3604
www.concentra.com

PLEASE FAX BACK INFO ON ATTACHED. THANKS

FAX

To:	CA / FRONT DESK	From:	CAROL
Fax:		Pages:	3 W/ COVER
Phone:		Date:	8/26/08
Re:		cc:	

Comments:

SECTIONS IV, V, + VI

AGENT FORM FILLED OUT. ALSO, DLD PT HAVE GLASSES OR CONTACTS W/ HIM? THANK

Concentra Medical Centers (NJ)

135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax: (732) 417-0003

PULMONARY FUNCTION TEST RECORD

Hicks, Ciro C.
Patient's Last Name, First Name and Middle Initial

5 Chanowich Ct.

MIDDLETOWN, NJ. 07748
Address:

Vane Brothers
Employer Name:

☐ (Check ✓ when print out is attached)

Employee SSN: [redacted]

Test Number: _____

Age 57

Test Date: _____

Race ☐ Black ☐ Hispanic ☐ White ☐ Asian ☐ Other:

Time of Test: _____

Sex: ● Male ○ Female

Location: ____ In Clinic ____ In Plant ____ Other

Height in Inches† _____

Check ✓ indicates the one that applies
☐ Non Smoker ☐ Former Smoker ☐ Smoker

Spirometer/Pulmonometer (circle one) (S) (P)

Hours Since Medication Used _____

Date of last calibration _____

List Medications Used: _____

Ambient Temp - C° _____

Hours Since Last Smoked _____

Complete this section when print out is not available
Observed Values (BTPS)

FEV1	FVC	FEV1/FVC%

Predicted Normals *

FEV1%	FVC%

Change (%)

FEV1 (> 8%)	FVC (> 8%)	FEV1/FVC% (> 6 %)

Attach Print Out Here Or To The Back Of This Form

Comments: _____

Technicians Name (Signature)

Technicians Name (Print)

* The predicted FEV and FVC in Black individuals must be multiplied by 0.85.
† In stocking feet
BTPS- Body Temperature Ambient Pressure Saturated with Water Vapor Calculation

Company Info:
Vane Brothers Co
2100 Frankfurst Avenue
Baltimore, MD 21226
Muriel Madden – HR Contact
Phone 410-631-5096
Fax 410-410-735-8160

Protocol Info: Merchant Mariner Preplacement Physical
1) Preplacement Physical
2) Audiogram
3) Breath Alcohol Test
4) HPE
5) Regulated UDS

If your MRO is NDI – NDI Account # is 4106311777. If your MRO is not NDI, please have results report back to Muriel Madden via e-mail at mmadden@vanebrothers.com.

6) *Pulmonary Function Test
7) *Chest X-ray 1-view
8) Vision Ishihara

Protocol Notes:
1-*PFT and Chest X-ray –only if deemed necessary by MD.
2-Employee may have a copy of their physical.
3-Any questions regarding Physical, please call Dr Hill 410-633-3600
4-Please complete Concentra's Preplacement Physical form as well as Merchant Mariner Physical Examination Report. Please check off Competent, Not Competent or Needing Further Review.
5-DO NOT MAIL ANY PAPERWORK TO COMPANY – Fax all paperwork to 410-975-4577 ATTN Marybeth.
6-If applicant fails **ANY PORTION** of the physical, immediately contact Vane HR 410-735-8146.
7-If Chest X-ray is required, fax results to Marybeth when received 410-975-4577

Thanks

Marybeth Ripley
410-218-2679

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5484 Fax: (732) 417-0003

Service Date: 08/12/2008

Audiometric Examination Record

Patient: Hicks, Ciro C.
SSN: [redacted]
DOB: [redacted]
Gender: M

Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748
Phone: (732) 615-9248

Employer: Vane Brothers
Address: 2100 Frankfurst Ave
BALTIMORE, MD 21226
Auth. by:

Contact: Michael Freitas
Role: Primary Contact
Phone: (410) 735-8235 **Ext.:**
Fax:

MEDICAL HISTORY (ANTECEDENTES MEDICOS)

Have you ever had: (Ha tenido o padecido alguna vez de:)

Mumps (Paperas)	Yes	No	Ringing in ears (Campaneo en los oidos)	Yes	(No)
Measles (Measles)	(Yes)	No	Dizziness (Mareos)	Yes	(No)
Diabetes (Diabetes)	Yes	No	Severe head injury (Algun golpe severo en la cabeza)	Yes	(No)
High Fever (Fiebres Altas)	Yes	No	Arthritis (Artritis)	(Yes)	No
Meningitis (Meningitis)	Yes	No	Recent sinus problems (Problemas recientes con su nariz)	Yes	(No)
High blood pressure (Alta Presión)	Yes	(No)	Diagnosed hearing loss (Se la ha diagnosticado de perdida de oir)	Yes	(No)
Allergies (Alergias)	Yes	(No)	Hearing loss in family (before age 50) (Perdida del oido en algún miembre de su familia de los 50 años de edad)	Yes	(No)
Ear infections (Infecciones en los oidos)	Yes	(No)	Wear a hearing aid (Usa dispositivo auditivo)	Yes	(No)
Perforation of ear drum (Perforación del timpano)	Yes	(No)			
Drainage from ear (Secreciones en los oidos)	Yes	(No)			

Employee signature (Firma de empleado)

Date

NON-OCCUPATIONAL HISTORY (ANTECEDENTES NO LABORALES)

Have you been exposed to: (Ha estado alguna vez expuesto a:)

Loud music (Musica muy alta)	Yes	(No)
Power tools (Herramientas de alta potencia)	Yes	(No)
Motorcycles (Motocicletas)	(Yes)	No
Gun fire (Disparos de armas)	Yes	(No)
Military service (Servicio Militar)	Yes	(No)

If yes, what branch _____ (Si su respuesta fue afirmativa, en que lugar)

OCCUPATIONAL HISTORY (ANTECEDENTES LABORALES)

Use hearing protection (Ha usado alguna vez protección para oidos) Yes No

Plugs _____ Muffs _____ (Tapones) (Orejeras)

Exposed to noise within the last 14 hrs? (Ha estado expuesto al ruido durante las ultimas 14 horas?) Yes No

OTOSCOPIC EVALUATION (if conducted):

	LEFT	RIGHT
Ear canal clear	Yes ✓ No __	Yes ✓ No __
Ear drum visible	Yes ✓ No __	Yes ✓ No __
Inflammation/Obstruction	Yes __ No ✓	Yes __ No ✓
Scarring of ear drum	Yes __ No ✓	Yes __ No ✓
Drainage from ear	Yes __ No ✓	Yes __ No ✓

Signature of physician

AFFIX AUDIOMETRIC RESULTS HERE:

	LEFT EAR	RIGHT EAR	
500	10	15	500
1K	15	10	1K
2K	10	15	2K
3K	25	40	3K
4K	20	50	4K
6K	25	10	6K
8K	20	20	8K

Hearing Loss Formula: $\frac{500\text{-}1000\text{-}2000\text{-}3000}{4}$ - 25 x 1.5

RESULTS:

- __ **Baseline - yes _____ no _____**
- __ Audiogram is acceptable
- __ Evidence of high frequency hearing loss on the _____ left and/or _____ right
- __ Evidence of hearing loss in the speech range: on the _____ left and/or _____ right
- __ Standard threshold shift noted
- __ Recommend repeat audiogram within 30 days
- __ Ear protection necessary at 85db. Employee informed.
- __ Employee advised to followup with his/her physician.

Comments: _____

Audiometer make & serial no: Tracmetrics RA500

Calibration date: 4/4/08

Technician signature: Joseph L. Lake

Service ID: 482076129
X-ray Number:

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 2[redacted] Fax: (732) 417-0003

Service Date: 08/12/2008
Case Date: 08/12/2008

Non-Injury Flowsheet

Patient: Hicks, Ciro C.
SSN: [redacted]
Age: 57 **DOB:** [redacted]
Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748
Home: (732) 615-9248
Work: **Ext.:**

Employer: Vane Brothers
Employer Location: Vane Brothers
Address: 2100 Frankfurst Ave
BALTIMORE, MD 21226
Auth. by:

Contact: Michael Freitas
Phone: (410) 735-8235 **Ext.:**
Contact: Michael Freitas
Role: Primary Contact
Phone: (410) 735-8235 **Ext.:**
Fax:

Examination Results

____ No Status Required
____ Recommend Further Evaluation

Medical Evaluation Results

____ Medical Evaluation Within Normal Limits
____ Medical Evaluation NOT Within Normal Limits
____ Not Applicable

Medical Restrictions

____ Medical Restrictions
____ No Medical Restrictions

Pending Results

____ Pending Results
____ Pending Medical Hold
____ Pending Medical Records
____ Pending Process Completion
____ No Pending

Remarks:

Medical Implications

____ Cardiovascular
____ Diabetes
____ Hypertension
____ Medications
____ Myocardial Infarction
____ Physical Impairment
____ Other (Comments Required)

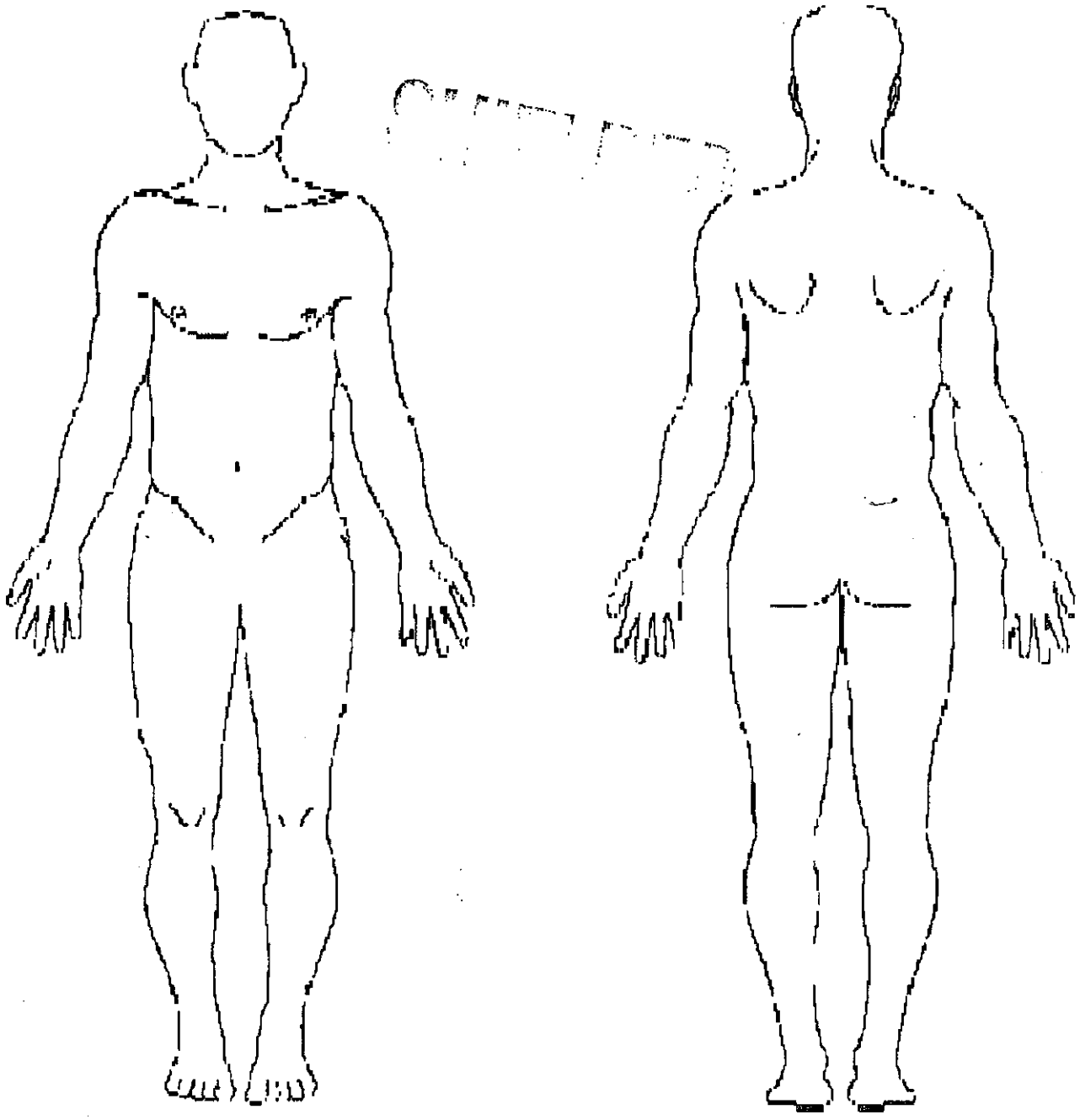
____ Seizures
____ Vision
____ Unverified Medical Information
____ Unresolved Medical Hold
____ Certification less than 2 years

____ Medication Allergy(s) (Comments Required)

Concentra Medical Centers (NJ)
136 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax: (732) 417-0003
Hicks, Ciro C. Date: 08/12/2008
SSN: [redacted] DOB: [redacted]
X-Ray# 001438

X-Ray

Service ID: 482076129
Service Date: 08/12/2008
Case Date: 08/12/2008
Employer: Vane Brothers



Service ID: 482076129
X-ray Number:
CO1438

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax: (732) 417-0003

Non-Injury Flowsheet

Service Date: 08/12/2008
Case Date: 08/12/2008

(2)

Patient: Hicks, Ciro C.
SSN: [redacted]
Age: 57 DOB: [redacted]
Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748
Home: (732) 615-9248
Work: Ext.:

Employer: Vane Brothers
Employer Location: Vane Brothers
Address: 2100 Frankfurst Ave
BALTIMORE, MD 21226
Auth. by:

Contact: Michael Freitas
Phone: (410) 735-8235 Ext.:
Contact: Michael Freitas
Role: Primary Contact
Phone: (410) 735-8235 Ext.:
Fax:

Previous Cases:

Case Date	Case Description	Employer Location	Market	Center	On-Line

Employer Notes:
NO INJURY CARE Location Notes: 6/22/06 new emp-hh

Protocol Notes:

PFT & Chest X-Ray only if deemed necessary by MD.
Any ?s regarding physical please call Dr Hill @ 410-633-3600.
Please complete Concentras physical form as well as Merchant Mariner physical form.
DO NOT MAIL ANY PPWK TO COMPANY.
Fax to _____ At tn:Marybeth.
If EE fails any portion of physical immediately contact V 410-735-8146.
If Chest X-Ray is required fax results to Marybeth ____

FOR COLLECTION SITE USE
109999063

FAXED
8-19-08
410-975-4577

Hicks, Ciro C.
Employer: Vane Brothers
SSN: [redacted]
Case Date: 08/12/2008 DOB: 07/16/1951
X-ray #:

Non-Injury Flow	Time	Initials		Time	Initials
Sign-In	10:50 am		Registration Complete		
Admit	10:51 am		Treatment Initiated		

Protocol: Merchant Mariner Phy	Time	Initials		Time	Initials
Audiogram			Breath Alcohol Test PrePlac		
HPE ADApt-Level 4			Physical PrePlacement		
Pulmonary Function Test			Regulated UDS PrePlaceme		
Vision Ishihara/Color			X-Ray Chest-1 View		
			Check Out		

Claim Number:

Service Date: 05/08/2009

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax (732) 417-0003

Non-Injury Status Report

Patient: Hicks, Ciro Charles
SSN: [redacted]
Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748
Home: (732) 533-7045
Work: **Ext.:**

Employer Location: Vane Brothers
Address: 2100 Frankfurst Ave
Baltimore, MD 212261026
Auth. by:

Contact: Michael Freitas
Role: Primary Contact
Phone: (410) 735-8235 **Ext.:**
Fax:

This Visit:

Time In: 10:54 am **Time Out:** 12:40 pm **Visit Type:** New

Fitness for Duty Physical Level
Fitness for Duty Physical-Level 4
Non Regulated UDS Random
Breath Alcohol Test Random

Result Status:

Unable to perform essential functions
Medical restrictions
Pending - Medical Hold

Remarks: Not cleared for full duty consider a MRI to rule out internal derangement of right shoulder.

(Date) May 8, 2009

Sent via facsimile to: 410-735-8271

Vane Line Bunkering, Inc.
2100 Frankfurst Street
Baltimore, MD 21226

Attention: Risk Department

RE: Patient: Charlie Hicks
(Please Print)

Dear Risk Dept:

This letter will certify that the undersigned has reviewed the below listed paperwork for the referenced patient, and has found the following results:

(Please circle one)

Pass	**Fail**	-	**Fit for Duty Physical Examination**
(Pass)	**Fail**	-	**Breath Alcohol Test**
Pass	**Fail**	-	**Human Performance Evaluation (ADApt-L4)**
(Vane Risk receives Non-regulated UDS)			***Non- Regulated* UDS (Sent from Lab to Employer)**

Therefore, based on the patient passing all segments of the Fit for Duty Medical Examination, and our review of same, it is our recommendation that the subject patient:

____ **Is Fit for Duty without restrictions/competent as of** _____;

____ **Is to return to work, ONLY with the following Accommodation/s:** NO USE OF Shoulder

____ **Further USCG review is required.**

Very truly yours,

Dr. _____
(Please Print Name and Sign)

Service ID: 482240455
X-ray Number: 001438

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax: (732) 417-0003

Non-Injury Flowsheet

Service Date: 05/08/2009
Case Date: 05/08/2009

Patient: Hicks, Ciro Charles
SSN: [redacted]
Age: 57 DOB: [redacted]
Address: 5 Chanowich Ct.
MIDDLETOWN, NJ 07748
Home: (732) 533-7045
Work: Ext.:

Employer: Vane Brothers
Employer Location: Vane Brothers
Address: 2100 Frankfurst Ave
Baltimore, MD 212261026
Auth. by:

Contact: Michael Freitas
Phone: (410) 735-8235 Ext.:
Contact: Michael Freitas
Role: Primary Contact
Phone: (410) 735-8235 Ext.:
Fax:

Previous Cases:

Case Date	Case Description	Employer Location	Market	Center	On-Line
08/12/2008	Non-Injury: Merchant Mariner Phy	Vane Brothers	Northern New Jersey	CMC - NNJ Edison	

Employer Notes:
NO INJURY CARE Location Notes: 6/22/06 new emp-hh

Protocol Notes:
cleared
Not fit for
Full Duty
Consideration
No answer
21/100 Ciro Hicks

Non-Injury Flow	Time	Initials		Time	Initials
Sign-In	10:54 am		Registration Complete		
Admit	10:54 am		Treatment Initiated		
Protocol: Fitness for Duty Phys	**Time**	**Initials**		**Time**	**Initials**
Breath Alcohol Test Randoi			Fitness for Duty Physical-Li		
HPE ADApt-Level 4			Non Regulated UDS Randoi		
			Check Out		

Hicks, Ciro Charles

FOR COLLECTION SITE USE
316759196

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax. (732) 417-0003

Service Date: 05/08/2009

ServiceID: 482240455

Return to Work Evaluation

Patient: Ciro Charles Hicks **Address:** 5 Chanowich Ct. **Employer:** Vane Brothers **Contact:** Michael Freitas
SSN: [redacted] **Address:** 2100 Frankfurst Ave **Role:** Primary Contact
DOB: [redacted] MIDDLETOWN, NJ 07748 Baltimore, MD 212261026 **Phone:** (410) 735-8235 **Ext.:**
Gender: M **Phone:** (732) 533-7045 **Auth. by:** **Fax:**

Race: ASIAN BLACK HISPANIC INDIAN WHITE OTHER

Reason for evaluation: ____________________

☐ Occupational with other provider ☐ Non-Occupational

Requested by: ____________________

Special attention to: ____________________

Treating provider: ____________________

Authorization for Examination

Permission is hereby granted to the authorities of Concentra Medical Centers (NJ) for any examination deemed necessary by the physician. In addition, I authorize the release of any information acquired in the course of this examination.

[signature] Patient Signature 5-8-09. Date

Examination

Temp: ______ Blood Pressure: 132/70 Pulse: 64 Ht: 71 Wt: 215

Other: ____________________

Medical History: (R) shoulder pain after 2006 weight fell on him. Seen by [illegible] ortho - treated with steroids after. Still has some residual pain - But wants to

[illegible] 5/[illegible]. [illegible] NFAR

Present Complaint: (R) Shoulder pain 4/21/09 [illegible] [illegible] [illegible]

Findings/Recommendations: [illegible]

(O) 150 flexion 200 abd (+) Hawkins (+) Speed

Physician's Signature Date

Shoulder strain R/O rotator cuff tear 5/8/09

[illegible handwriting]

CONCENTRA
MEDICAL CENTERS

Permission to Allow Third Party Presence During Patient Examination

I Nina C Ortiz, consent to having a representative of my employer, Janet Ortiz, present during my examination. I understand that allowing a third party to be present during my examination will result in the disclosure of my medical information being discussed during the examination, to the third party. If information not related to my injury needs to be discussed, I may ask the representative to leave the room.

I understand that this consent may be revoked at any time during the examination by notifying the healthcare provider or the employer representative.

I understand that Concentra is not responsible for any information that is gathered or used by my employer as a result of this consent.

This consent is valid for all future visits related to my work injury/illness unless revoked by me.

Signature

5-2-09
Date

Risk Department
2100 Frankfurst Ave
Baltimore, MD, 21226
Ph: 410-735-8228
Fax 410-735-8271

VANE LINE BUNKERING INC.

Fax

Vane Brothers

To:	Dr. Tobias and Vlad, PT	**From:**	Marge Lukas, Claims Specialist
Attn:	Noami	**Date:**	May 7, 2009
Fax:	732-417-0003	**Phone:**	732-225-5454
Re:	Charlie Hicks	**Pages:**	

Urgent **For Review** **Please Comment** **Please Reply** **Please Recycle**

HIPAA SECURE RETURN FAX NO.: 410-735-8271

Dear Noami, Thank you for your time on the phone and for passing all of the needed forms to either Dr. Tobias and/or Vlad. Mr. Hicks will be there at 0900 on May 8, 2009. The attached Letter for Doctor review also outlines all of the tests that need to be done: fit for duty physical exam; BAT; HPE AdApt – L4 and Non-Regulated UDS.

Dear Dr. Tobias, On 4/23/09, Mr. Hicks reported that on 4/21/09, he was trying to lift a large metal collar on a texas bar and "pulled on his shoulder." He saw Dr. Murphy at Orthopedics office. The evaluation note is not yet back from transcription; however, the nurse read the chart and report DX as "Pain shoulder joint." She noted a steroid injection was done to the shoulder. Mr. Hicks reports he is symptom free and ready to go back to work.

Please review all of the attached records and documents. Please call me if you have any questions or concerns.

Sincerely,

Marge Lukas

Alcohol Testing Form (Non-DOT)

(The instructions for completing this form are on the back of Copy 3)

STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name (Print) (First, M.I., Last) Ciro C Hicks

B: SSN or Employee ID No. [redacted]

C: Employer Name Vane Brothers

Street 2100 Frankfurst Ave

Baltimore, MD 21226

City, ST ZIP

DER Name and Telephone No. Margie Lukas (DER Name) 410 735 9220 (DER Area Code & Phone Number)

D: Reason for Test: ☐ Random ☐ Reasonable Susp. ☐ Post-Accident ☑ Return to Duty ☐ Follow-up ☐ Pre-employment

STEP 2: TO BE COMPLETED BY EMPLOYEE

I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correct.

Signature of Employee [signature] Date 05/08/09 (Month / Day / Year)

STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN

(If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results are as recorded.

TECHNICIAN: ~~☑ BAT~~ ☐ STT DEVICE: ☐ SALIVA ☑ BREATH* 15-Minute Wait: ☐ Yes ☑ No

SCREENING TEST: *(For BREATH DEVICE* write in the space below only if the testing device is not designed to print.)*

Test #	Testing Device Name	Device Serial # OR Lot # & Exp. Date	Activation Time	Reading Time	Result

CONFIRMATION TEST: *Results MUST be affixed to each copy of this form or printed directly onto the form.*

REMARKS:

Alcohol Technician's Company Concentra

Company Street Address Edison 08837

(PRINT) Alcohol Technician's Name (First, M.I., Last) [illegible]

Company City, State, Zip

Phone Number (Area Code & Number) 732 225 5454

Signature of Alcohol Technician [signature] Date 05/07/09 (Month / Day / Year)

STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive.

Signature of Employee Date Month / Day / Year

471-FS-C3 (Rev. 6/01) 6363

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER

Service ID: 482240455
X-ray Number: 001438

Concentra Medical Centers (NJ)
135 Raritan Center Pkwy EDISON, NJ 08837
Phone: (732) 225-5454 Fax: (732) 417-0003

Service Date: 05/08/2009
Case Date: 05/08/2009

Non-Injury Flowsheet

Patient: Hicks, Ciro Charles
SSN: [redacted] Employer: Vane Brothers Contact: Michael Freitas
Age: 57 DOB: [redacted] Phone: (410) 735-8235 Ext.:
Address: 5 Chanowich Ct. Employer Location: Vane Brothers Contact: Michael Freitas
MIDDLETOWN, NJ 07748 Address: 2100 Frankfurst Ave Role: Primary Contact
Home: (732) 533-7045 Baltimore, MD 212261026 Phone: (410) 735-8235 Ext.:
Work: Ext.: Auth. by: Fax:

Examination Results

____ No Status Required
____ Recommend Further Evaluation

Medical Evaluation Results

____ Medical Evaluation Within Normal Limits
____ Medical Evaluation NOT Within Normal Limits
____ Not Applicable

Medical Restrictions

____ Medical Restrictions
____ No Medical Restrictions

Pending Results

____ Pending Results
____ Pending Medical Hold
____ Pending Medical Records
____ Pending Process Completion
____ No Pending

Remarks:

Medical Implications

____ Cardiovascular
____ Diabetes
____ Hypertension
____ Medications
____ Myocardial Infarction
____ Physical Impairment
____ Other (Comments Required)
____ Seizures
____ Vision
____ Unverified Medical Information
____ Unresolved Medical Hold
____ Certification less than 2 years
____ Medication Allergy(s) (Comments Required)

DANMAR ASSOCIATES

Disability Case Management ♦ Vocational Rehabilitation Services

Swedesford Corporate Center
631-B Swedesford Road
Frazer, PA 19355
610-993-9941
610-993-9902 fax

JOB ANALYSIS

Company: Vane Line Bunkering **Job Title:** Captain/Mate

The following are based upon a 2 week on, 2 week off schedule, working 2 6-hour shifts over a 24-hour period i.e., 6 hours on, 6 hours off, 6 hours on, 6 hours off.

	Occasionally (Up to 33%)	Frequently (34% - 66%)	Continuously (67% - 100%)	Never
LIFT				
0-10 lbs.	X			
11-20 lbs.	X			
21-50 lbs.				X
51-100 lbs.				X
CARRY				
0-10 lbs.	X			
11-20 lbs.	X			
21-50 lbs.				X
51-100 lbs.				X
STAND		X		
WALK	X			
SIT	X			
PUSH	X			
PULL	X			
CLIMB	X			
BEND	X			
KNEEL				X
TWISTING				X
CRAWL				X
REACH		X		
HANDLE		X		
FINGER		X		

Environmental Conditions: Inside (80%) Outside (10%) Temp. Range varies w/weather conditions.

Fumes/Dust:	Minimum ( )	Moderate (X)	Severe ( )
Noise Level:	Minimum ( )	Moderate (X)	Severe ( )

Protective Clothing/Personal Devices: Safety shoes and hearing protection.

Job Analysis Completed By: Danmar Associates Date: 11/7/05
Reviewed By: Vane Line Bunkering Date: 11/8/05

APPROVED/Signature of Physician X _____ Date: 5/4/09

DISAPPROVED/Signature of Physician _____ Date: _____

DANMAR ASSOCIATES

Disability Case Management ♦ Vocational Rehabilitation Services

Swedesford Corporate Center
631-B Swedesford Road
Frazer, PA 19355
610-993-9941
610-993-9902 fax

JOB ANALYSIS

Name: Charlie Hicks **Job Title:** Captain/Mate

Company: Vane Line Bunkering

The following are based upon a 2 week on, 2 week off schedule, working 2 6-hour shifts over a 24-hour period i.e., 6 hours on, 6 hours off, 6 hours on, 6 hours off.

	Occasionally (Up to 33%)	Frequently (34% - 66%)	Continuously (67% - 100%)	Never
LIFT				
0-10 lbs.	X			
11-20 lbs.	X			
21-50 lbs.				X
51-100 lbs.				X
CARRY				
0-10 lbs.	X			
11-20 lbs.	X			
21-50 lbs.				X
51-100 lbs.				X
STAND		X		
WALK	X			
SIT	X			
PUSH	X			
PULL	X			
CLIMB	X			
BEND	X			
KNEEL				X
TWISTING				X
CRAWL				X
REACH		X		
HANDLE		X		
FINGER		X		

Environmental Conditions: Inside (80%) Outside (10%) Temp. Range varies w/weather conditions.

Fumes/Dust:	Minimum ( )	Moderate (X)	Severe ( )
Noise Level:	Minimum ( )	Moderate (X)	Severe ( )

Protective Clothing/Personal Devices: Safety shoes and hearing protection.

Job Analysis Completed By: Danmar Associates Date: 11/7/05
Reviewed By: Vane Line Bunkering Date: 11/8/05

APPROVED/Signature of Physician _____ Date: _____

DISAPPROVED/Signature of Physician _____ Date: _____

Concentra. Medical Centers

Vane Brothers

Client Name: Charlie Hicks

SSN: N/A

Date of Test: MAY 8, 2009

Baseline Heart Rate:	
Age Predicted Maximum 220-Age:	
85% of Age Predicted Maximum 220- Age x .85:	

Testing will be stopped for any component, if the candidate's heart rate level reaches 85% of their Age Predicted Maximum. Testing may resume when the candidate's heart rate returns to their baseline heart rate level.

Material Handling Activities

	Weight	Activities		Repetitions	Score	HR
Lift	40	Floor to Waist		2	Pass / Fail	
Lift	40	Waist to Shoulder		2	Pass / Fail	
Lift	40	Waist to Overhead		2	Pass / Fail	
Carry	40	Distance: feet	20	2	Pass / Fail	
Push-Pull	40 lbs of force	Distance: feet	400	2	Pass / Fail	
UE Push-Pull	27 lbs of force	Distance:	UE only	2	Pass / Fail	
Simulated Rope Toss		20 lbs on cable column		3 on each side	Pass / Fail	
Grip Strength	40 lbs of force	Average of 4 trials:			Pass / Fail	
Pinch Strength	15 lbs of force	Average of 4 trials			Pass / Fail	
Hand Dominance:						

Non-Material Handling

Activity	Repetitions	Score	
Climbing up and down ladder x 20 rungs	1	Pass	Fail
Crawling in and out of a 24" x 24" opening	1	Pass	Fail
Balance Test: 30 sec single leg stance on each leg on a foam cushion	1	Pass	Fail
Step over a 24" step	5	Pass	Fail
Crawl a distance of 16 feet	2	Pass	Fail
Ambulate 400 feet at a pace of not less than 5 feet per second.	1	Pass	Fail
BAPS board with level 2 ball	Must hold for 2 sec x 3 times	Pass	Fail

Test Administrator:

Comments:
(To be completed by the candidate after the completion of the evaluation)

Do you feel that you can safely perform these types of activities on a daily basis as part of your regular duty position? _____Yes _____No

Candidates Signature:_____ Date: _____

Therapist's Comments:

Therapist's Signature:

Evaluator's Observations:	Yes	No
1. Did the candidate utilize good body mechanics and proper material handling techniques?		
2. Did the candidate appear to have normal gross coordination?		
3. Did the candidate appear to fatigue easily?		

g. Enclosure (4) contains information about illegal substances and intoxicants, and a non-exhaustive list of medications that may be subject to further medical review in accordance with enclosure (6).

h. Enclosure (5) contains guidance for evaluating vision and hearing.

i. Enclosure (6) describes the medical review process.

j. Applicants for credentials should utilize form CG-719K or form CG-719K/E, as appropriate. Use of an equivalent form is acceptable if it includes the same information; however, an equivalent form should be submitted to the NMC for review prior to use. Submission of inadequate information will result in processing delays. Medical practitioners should review each page of the form. Forms and information about the medical review process are publicly available on the HOMEPORT internet website at: http://homeport.uscg.mil/mycg/portal/ep/browse.do?channelId=-25023.

k. Some individuals may have conditions or limitations that are not listed which would render them incapable of performing their duties. Others with a listed condition or limitation may be quite capable of working at sea without posing a risk to the ship, their shipmates, or themselves. While each applicant is evaluated individually, the conditions described in this NVIC are those which may be subject to further review in accordance with enclosure (6) before a credential can be issued.

l. In situations where the applicant does not meet the standards specified in references (a) through (d), as supplemented by the guidance contained herein, waivers, limitations, and/or conditions of issuance may be considered by the NMC. The supplemental medical records, consultations, and test results listed in enclosure (3) should be submitted. *See* 46 CFR 10.205(d)(4) and enclosure (6).

m. Maritime academies should ensure that new entrants into a cadet program are physically and medically qualified. A cadet with a condition listed in enclosure (3) should be advised as early as possible that he or she may not be physically or medically eligible upon graduation to receive a credential. Medical staff at an academy may consult with the NMC. While a final determination cannot be made until an application is submitted prior to graduation, the NMC can advise that based on the cadet's present condition, a credential would probably (or probably not) be issued if he or she were applying for a credential at the present time.

n. Nothing in this NVIC precludes marine employers from establishing more rigorous medical or physical ability guidelines.

6. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor is it itself a regulation. It is not intended to nor does it impose legally-binding requirements on any party. It represents the Coast Guard's current thinking on this topic and is issued for guidance purposes to outline methods of best practice for compliance with the applicable law. You may use an alternative approach if the approach satisfies the requirements of the

MEDICATIONS

The following is a non-exhaustive list of prescription and over-the-counter medications that may be subject to further medical review in accordance with enclosure (6).

Anti-Depressants: Waiver is required, excluding use as a smoking cessation aid and with Premenstrual Dysphoric Disorder (PMDD).

Anti-Motion Sickness Agents: Use is approved when used in accordance with manufacturers' warnings and directions.

Anti-Psychotics: Waiver is required.

Anti-Convulsives: Waiver is required.

Anti-Histamines: Non-sedating medications, such as loratadine (Claritin), fexofenadine (Allegra) and desloratadine (Clarinex), are acceptable when used in accordance with manufacturers' warnings and directions. Sedating medications used during, or within 24 hours prior to, acting under the authority of the credential require a waiver.

Barbiturates, Mood Ameliorating, Tranquilizing, or Ataraxic Drugs: Waiver is required.

Benzodiazepines: Waiver is required if used during, or within 7 days prior to, acting under the authority of the credential.

Cough Preparations with Dextromethorphan, Codeine, or other Codeine-Related Analogs: Use of over-the-counter medications is approved when used in accordance with manufacturers' warnings and directions. Prescription medications require waiver if used during, or within 24 hours prior to, acting under the authority of the credential.

Diet Aids (e.g. Dexatrim, Metabolife, etc.) and Stimulants (e.g. modafinil, amphetamines, etc.): Use of over-the-counter medications is approved when used in accordance with manufacturers' warnings and directions. Prescription medications require waiver if used during, or within 48 hours prior to, acting under the authority of the credential.

Hypnotics (sleeping aids) and Sedatives: Waiver is required if used during, or within 48 hours prior to, acting under the authority of the credential.

Legally Prescribed Controlled Substances (including legally prescribed narcotics and legally prescribed medications which contain narcotics such as Tylenol w/ codeine): No waiver required if not used during, or within 48 hours prior to, acting under the authority of the credential. May be waiverable under exceptional circumstances if used during, or within 48 hours prior to, acting under the authority of the credential.

MEDICATIONS

Medical Use of Hallucinogens (e.g. medical marijuana, peyote or ecstasy): Even if legalized by a state, is **not** waiverable under any circumstances.

Muscle Relaxants: Centrally acting (e.g.carisoprodol, meprobamate, cyclobenzaprine, methocarbamol, orphenadrine citrate, benzodiazepines, antimuscarinics and antihistamines, phenyltoloxamine, etc.): Waiver is required if used during, or within 48 hours prior to, acting under the authority of the credential.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION
118	Deformities, either congenital or acquired causing significant functional impairment and/or interfering with the ability to wear required personal protective equipment	Physical medicine, occupational medicine or orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
119	Limitation of motion of major joint causing significant functional impairment	Physical medicine, occupational medicine or orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
120	Neuralgia or Neuropathy, chronic or acute causing significant functional impairment	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
121	Sciatica causing significant functional impairment	Neurology or orthopedic consultation to include sufficient documentation to exclude specific causes of back pain, functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
122	Osteomyelitis, acute or chronic, with or without draining fistula(e) causing significant functional impairment	Orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
123	Tremors causing significant functional impairment	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
124	Osteoarthritis causing significant functional impairment	Rheumatology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies. Note: Waiver considered for an applicant who is taking aspirin, ibuprofen, naproxen, similar nonsteroidal anti-inflammatory drugs (NSAID), or COX-2 inhibitors; however, the applicant should present evidence documenting that the underlying condition for which the medicine is being taken is not in itself disabling and the applicant has been on therapy (NSAID) long enough to have established that the medication is well tolerated and has not produced adverse side effects.

Company: Vane Brothers

Job Title: Captain/Mate

Federal Classification: Medium

Job Function: Commands tugboat to tow barges into and out of oceans, bays, rivers, coastal waters, and harbors.

Essential Functions:

- Supervises and coordinates activities with crew aboard tugboat.
  - Insures safe operation of vessel.
- Communicates with crewmembers and barge captain in preparation of hook up with barge or with ship at sea.
- Signals workers on deck to rig tow-lines to barges.
  - Operates loud-speaker or hand-held radio.
- Communicates with dispatch via radio/phone or computer.
- Determines course and towing speed on basis of specialized knowledge of winds, weather, tides, and currents.
  - Utilizes GPS, charts and tidal current tables.
  - Maintains communication with headquarters.
- Signals passing vessels using whistles, flashing lights, flags, and radios.
- Operates vessel from wheelhouse or elevated wheelhouse.
- Arranges for tugboat to be fueled, restocked with supplies, and/or repaired.
- Inspects tugboat to insure crew safety and compliance with regulatory guidelines and procedures.
- Authorizes procurement of supplies and other outfitting needs.
- Manages overall operation of tugboat.

Specific Vocational Preparation

Level – 8: Classified as skilled work. Person is considered trained for the occupation with between 4 years and 10 years of experience; includes vocational education, apprenticeship, in-plant, on-the-job, and/or essential experience gained on other jobs.

Minimum General Educational Requirements

Reasoning	Level 4 (Grades 9-12)
Mathematics	Level 3 (Grades 7-8)
Language	Level 3 (Grades 7-8)

Range of Motion (degrees)

Cervical Spine	
Flexion	20/25
Extension	25/30
Lateral Bending	20/25
Rotation	N/A

5. DISCUSSION.

a. This NVIC is a resource to assist medical personnel in performing examinations of applicants. It provides guidance on conditions that are subject to further review for issuance of credentials and the recommended medical supplemental tests and evaluations. Medical practitioners should provide comments and recommendations with regard to the ability of applicants to meet the appropriate standards in references (a) through (d). The final determination regarding issuance of all credentials lies with the Coast Guard.

b. Service on vessels may be arduous and impose unique physical and medical demands on mariners. The public safety risks associated with the medical and physical conditions of mariners on vessels are important considerations for the safe operation of vessels. In the event of an emergency, immediate response may be limited to the vessel's crew, and outside help may be delayed. Mariners must be medically and physically fit to perform their duties not only on a routine basis but also in an emergency.

c. This NVIC has been developed by the Coast Guard in consultation with experienced maritime community medical practitioners and industry stakeholders. This NVIC reflects a synthesis of their recommendations, the requirements in references (a) through (d), and the recommendations of other federal transportation mode authorities as to appropriate physical and medical standards. The public was also afforded opportunity to comment on a draft of this NVIC. *See* 71 FR 56998 (September 28, 2006).

d. Enclosure (1) provides medical certification standards as set forth in reference (c). Enclosure (1) lists the standards that apply to applicants for each of the various types of credentials.

e. Enclosure (2) provides guidance for determining if mariners are physically able to perform their duties. For purposes of this NVIC, a medical condition is considered to cause "significant functional impairment" if it impairs the ability of the applicant to fully perform all of the physical abilities listed in this enclosure, or if it otherwise interferes with the ability of the applicant to fully perform the duties and responsibilities of the requested credential. Applicants with physical limitations who do not meet the related physical ability guidelines contained in enclosure (2) may be issued a credential with appropriate limitations as specified by the NMC.

f. Enclosure (3) contains a non-exhaustive list of medical conditions subject to further review and supplemental medical data that should be submitted for such medical review. Not all of the medical conditions listed in enclosure (3) require a waiver. Applicants with these medical conditions may be issued credentials with or without limitations, waivers and/or other conditions of issuance as specified by the NMC. This is further discussed in enclosure (6).

(1) Enclosure (3)(a) contains an index of the medical conditions listed in enclosure (3).

(2) Enclosure (3)(b) contains a table of abbreviations used in enclosure (3).